



TWCC # _____
Carrier # _____

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name	2. Employer phone #
3. Employer mailing address	
4. Insurance carrier name	
5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes <input type="checkbox"/> no <input type="checkbox"/> If so, identify contact person and phone # _____	
6. Has the insurance carrier provided RTW coordination services within the past 12 months?	yes <input type="checkbox"/> DATE _____ no <input type="checkbox"/>
7. Has the employer requested RTW training from TWCC or the insurance carrier?	yes <input type="checkbox"/> no <input type="checkbox"/>
8. Has the insurance carrier provided accident prevention services in the past 12 months?	yes <input type="checkbox"/> DATE _____ no <input type="checkbox"/>
9. Has the employer requested accident prevention services from the insurance carrier?	yes <input type="checkbox"/> no <input type="checkbox"/>

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. <input type="checkbox"/> a. The injured worker returned to work in either a full or limited capacity: File this report within 3 days.
<input type="checkbox"/> b. The injured worker is earning more or less than the pre-injury wage because of the injury: File within 10 days.
<input type="checkbox"/> c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury: File within 3 days.
<input type="checkbox"/> d. The injured worker resigned or was terminated from employment: File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name	12. SSN	13. DOI
14. Injured worker mailing address and phone #		
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)	16. First day of additional lost time or reduced wages (mm/dd/yyyy)	
17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes <input type="checkbox"/> no <input type="checkbox"/> If yes, the date of the 8th day (mm/dd/yyyy) _____		
18. Date of most recent RTW _____ <input type="checkbox"/> Full duty, full pay <input type="checkbox"/> Limited duty, full pay <input type="checkbox"/> Limited duty, reduced pay	19. Has the injured worker resigned, been terminated, or died? yes <input type="checkbox"/> no <input type="checkbox"/> date of resignation _____ date of termination _____ date of death _____ 19a. Reason for resignation/termination _____ 19b. Was the injured worker on limited duty when terminated? yes <input type="checkbox"/> no <input type="checkbox"/>	
20. Hours the injured worker was working during the pay period of _____ to _____: _____ hours per week Indicated hours are: <input type="checkbox"/> Increase from pre-injury <input type="checkbox"/> Same as pre-injury <input type="checkbox"/> Decrease from pre-injury	21. Weekly/hourly earnings for the pay period of _____ to _____: \$ _____ weekly or \$ _____ hourly Indicated wages are: <input type="checkbox"/> Increase from pre-injury wage <input type="checkbox"/> Same as pre-injury wage <input type="checkbox"/> Decrease from pre-injury wage	

This form to be filed with: *The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.*

22. To the best of my knowledge, the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
Submitted by: ☐ Employer ☐ Injured Worker (if no longer working for the employer where injury occurred.)

Signature and Title of person completing this form

Date

